Community-Based Adult Services (CBAS): IPC, TAR and H&P Form Completion

Most Community-Based Adult Services (CBAS) services require submission of a *Treatment Authorization Request* (paper TAR 50-1 or electronic eTAR) to the Los Angeles Medi-Cal field office for each Medi-Cal recipient. CBAS initial assessment and transition days do not require a TAR. CBAS regular days of attendance require a TAR, except if the services are provided by a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

When a TAR is submitted for CBAS regular days of attendance, a specified number of days of service, based upon days per calendar month, may be authorized for a period of up to six months. Approved CBAS services may be rendered on any day of the calendar month for which they were approved. The total number of days billed is not to exceed the total number of days authorized on the TAR for that calendar month, except for carry-over days. Claims for CBAS services in excess of the number of days per calendar month specified on an approved TAR will not be reimbursed, with the exception of carry-over days. Refer to "Carry-Over Days" on a following page for additional information. Initial and subsequent TARs may be approved for up to six calendar months.

Note: Pursuant to *California Code of Regulations* (CCR), Title 22, Section 51470 and *Welfare and Institutions Code* (W&I Code), Section 14107, it is illegal for providers to bill for services not yet provided. The Department of Health Care Services (DHCS) reserves the right to audit any CBAS center claim and will refer inappropriate claiming for investigation to the Bureau of Medi-Cal Fraud Prevention and the Department of Justice.

Settlement Agreement

The changes outlined below and contained within these provider manual pages are the subject of a court settlement agreement in the Darling et al. v. Douglas et al. litigation, C09-03798 SBA, which was approved by the Court on January 24, 2012. A copy of the settlement agreement is available at: http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC,aspx.

Per the settlement agreement, ADHC is eliminated as a payable benefit under the Medi-Cal program effective March 31, 2012 and is replaced with a new program called Community-Based Adult Services (CBAS) effective April 1, 2012. DHCS is seeking approval by the Centers for Medicare and Medicaid Services (CMS) to amend the currently approved "California Bridge to reform" Demonstration Waiver to include CBAS. The proposed amendment would provide this additional benefit to eligible Medi-Cal beneficiaries including those who are dually-eligible for Medicare and Medi-Cal.

Treatment Authorization Requests (TARs) will not be approved for ADHC services rendered on or after April 1, 2012, or starting the first day of the month following approval of the waiver amendment, whichever is later. For existing approved TARs, those ADHC services rendered on or after April 1, 2012, or upon approval of the waiver amendment, whichever is later, will not be reimbursed.

Existing ADHC providers may enroll as CBAS providers if they meet all specified requirements, and will continue to provide the same service package as they did under the ADHC program. Current ADHC participants will be able to receive CBAS if they meet the new eligibility and medical necessity criteria.

Beginning April 1, 2012, or upon approval of the waiver amendment, whichever is later, services may be provided and reimbursed only under the CBAS program. ADHC providers must be enrolled as CBAS providers in order to receive reimbursement for CBAS.

Except for the eligibility and medical necessity criteria, the policy changes made in January 2008 under SB 1755 (2006) remain in effect.

See the *Community-Based Adult Services (CBAS)* section in this Provider Manual for a complete discussion of specific provider requirements and eligibility and medical necessity criteria.

H&P Signature Page and IPC Form Accompany TAR

All TARs shall be initiated by the CBAS center, and must include the participant's IPC form, pursuant to CCR, Title 22, Section 54211. Refer to the following pages in this section for additional information and a photocopiable IPC form.

Initial TARs must also include the signature page of the History and Physical Examinations (H&P) form (when implemented) that serves to document the request for CBAS services. A complete H&P form, including a request for CBAS services signed by the participant's personal health care provider (or CBAS center physician, pursuant to W&I Code, Section 14528.1), must be maintained in the participant's health record.

Every six months, the CBAS center must initiate and document a request for updated H&P information from the participant's personal health care provider using the H&P Update form. The CBAS center shall maintain this form in the participant's health record at the CBAS center, if received.

Note: Separate reimbursement for completion of these forms is not available to the personal health care provider nor to the CBAS center's staff physician. The participant's personal health care provider, however, may receive reimbursement as part of an office visit.

The CBAS center is responsible for obtaining the information necessary to medically justify the authorization of CBAS services. When reviewing CBAS TARs and IPCs, the Medi-Cal field offices will apply the eligibility criteria specified in the Settlement Agreement and listed in the *Community-Based Adult Services (CBAS)* section of this provider manual or as approved under the final waiver.

TAR Completion and Form Example

When preparing and submitting a TAR, refer to instructions in the *TAR Completion* section in this manual. For TAR form examples, see *Figure 1* on a following page in this section and the *TAR Completion* section in this manual.

Items specific to CBAS should be completed as follows:

- Submit a completed IPC, along with a TAR to the Los Angeles Medi-Cal Field Office (LAMFO) that handles the CBAS adjudication.
- Enter in the *Medical Justification* area:
  - "See attached Individual Plan of Care"
  - Admission date
  - Total number of days requested in the six-month period
- Indicate the following in the *Specific Services Requested* area:
  - CBAS, month of requested service, inclusive dates (for example, "CBAS, May 14–31, 2012"). Each calendar month must be specified on a separate line of the TAR.
  - The requested number of days of service for the specified calendar month. This number must reflect the fewest number of days needed to carry out the IPC.
  - The requested "From" and "To" dates of the TAR.

  Note: The CBAS provider completes the service date field and should not begin providing CBAS to the recipient until the center has received an adjudication response from the LAMFO. If the CBAS provider begins providing CBAS to the recipient prior to notification of the approved TAR, it is at the risk of no reimbursement if the field office does not authorize the recommended number of days requested.
- Enter the appropriate procedure code in the *NDC/UPC Or Procedure Code* box. A procedure code (same as a service code) is required only for regular days of service. For specific service codes, refer to the *Community-Based Adult Services (CBAS): Billing Codes and Reimbursement Rates* section in this manual.
- Enter the total number of days of service requested for the specified calendar month on each line of the TAR in the *Quantity* box.

Transmittal Form (MC 3020)

When submitting paper TARs, IPCs and/or the signature page of the H&P form to the Los Angeles Medi-Cal field office with a TAR *Transmittal Form* (MC 3020), enclose a self-addressed stamped envelope. The field office will use the envelope to return a copy of the date-stamped transmittal form. MC 3020 (8/99) forms can be located on the Forms page of the Medi-Cal website at *www.medi-cal.ca.gov.*

Incomplete Submissions: Resubmission Turnaround Document (RTD)

With the exception of claims for assessment and transition days, claims submitted without obtaining authorization of a TAR are returned through the Resubmission Turnaround Document (RTD) process. Refer to the *Resubmission Turnaround Document (RTD) Completion* section in this manual.

Request for Increase in Days of Service (Change TAR)

A TAR and IPC must be submitted if the number of days approved on the current TAR must be increased due to a change in the participant's condition or service needs.

The TAR should be completed in full as follows:

- In the *Medical Justification* area, enter: "The number of service days per month authorized on _____ (TAR Control Number) has been increased on this TAR. See attached IPC for explanation"
- The "From" and "To" dates for additional services
- The total "Units of Service" is the total number of additional days between the "From" and "To" dates

The new IPC should be completed as follows:

- On page 1, place an "X" in the "Change TAR" box in Box 1.
- The *Participant Problem, Treatments/Interventions*, *Frequency of Treatments/Interventions* and *Discipline Specific Objective/Goal of Treatment/Intervention* (Boxes 21 and 22) areas must state the need for an increase in the days of service.
- Boxes 2 – 23 must be updated to include the reason(s) for the increase in days of service.
- Signatures of the participant's personal health care provider or CBAS center physician, registered nurse, social worker, any other discipline providing services and program director must be entered in the *Signatures of Multidisciplinary Team and Program Director* areas (Box 24) of the IPC form.

Lapsed (Expired) TARs

When the participant is away from the center (not attending on their previously scheduled days) for some period of time, a currently authorized TAR may lapse or expire. If the participant has not yet returned to the CBAS center, the CBAS center will not be able to obtain a reauthorization TAR.

If and when the participant returns to the CBAS center, the CBAS center must conduct all required assessments/reassessments and complete and submit a TAR and IPC according to standard instructions, with the following exceptions.

The TAR should be completed as follows:

- In the *Specific Services Requested* area, the "From" date is the date the center began providing services again.

The IPC should be completed as follows:

- In Box 23, give a full explanation of the extended absence.
- On page 1, place an "X" in the "Initial" box, Box 1 (regardless of the length of, and reason for the participant's absence and subsequent lapsed TAR; the first TAR after a previous TAR has lapsed is <u>always</u> considered an initial TAR).

The CBAS center must ensure that all of the requirements for an initial admission are met, including a current TB clearance (must have been done and determined negative within one year of return to the CBAS center), a current home assessment (if there is reason to believe that the home situation has changed, the CBAS center must complete another home visit), and current MDT assessments, IPC and H&P as needed.

If the participant returns before the current TAR period has ended, a new TAR is not necessary. The time remaining on the current TAR should be completed and a new TAR submitted as a reauthorization TAR when the current TAR period has ended. The participant's absence must be noted and explained in the participant's health record.

CBAS centers are encouraged to develop specific policies and procedures for their individual center regarding lapsed (expired) TARs, including when the participant is discharged. The center will be expected to maintain documentation in the health record regarding absences and follow-up done by the center.

Number of Days

When determining the appropriate number of days per calendar month to authorize, a Medi-Cal consultant will consider the following five factors:

- Overall health condition of the participant, relative to the participant's ability and willingness to attend the number of days requested, specified on the TAR and IPC
- Frequency of services specified on the IPC
- The extent to which other services currently being received by the recipient meet the recipient's needs, as specified on the TAR and IPC
- Number of days requested on the TAR
- If the personal health care provider or CBAS center physician has requested a specific number of days

When requesting the number of days per calendar month, the provider must ensure that the request is related to the participant's problem(s) and the number of days needed to carry out the IPC.

The Medi-Cal consultant authorizes CBAS services on the basis of a specific number of days per calendar month. The CBAS center must specify the months and the number of requested days for each calendar month on separate lines of the TAR. For example, for a six-month request, there should be six lines filled in on the TAR. See the example below:

LINE NO.	AUTHORIZED Y / N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1			CBAS SERVICES 040912 THRU 043012		S5102	10	
2			CBAS SERVICES 050112 THRU 053112		S5102	12	
3			CBAS SERVICES 060112 THRU 063112		S5102	12	
4			CBAS SERVICES 070112 THRU 073012		S5102	12	
5			CBAS SERVICES 080112 THRU 083112		S5102	12	
6			CBAS SERVICES 090112 THRU 093012		S5102	12	

- The Medi-Cal consultant will authorize the total number of days per month for up to six months.
- The CBAS provider should continue to specify the number of planned days per week on the TAR in the *Medical Justification* section.

The CBAS center may schedule attendance of the participant authorized for CBAS services for any day(s) during the month, based on the participant's needs, and so long as the total number of days attended by the participant during the month does not exceed the number of days authorized on the TAR for that calendar month, except for carry-over days.

Claims for CBAS services will <u>not</u> be reimbursed for days in excess of the number of days per calendar month authorized on the TAR, except for carry-over days. Claims for any day(s) not authorized on the TAR for that calendar month will be denied, except for carry-over days.

Carry-Over Days

A carry-over day is defined as a day of attendance that was:

- Authorized on the TAR for the previous calendar month
- Not attended by the recipient on the day planned nor on any other day during the previous calendar month
- Not reimbursed for the previous calendar month
- Subsequently attended as an extra day during the calendar month following the month in which it was authorized

Note: A planned day that is missed, rescheduled and subsequently attended within the same calendar month is not a carry-over day. Carry-over days cannot be reimbursed in the first month of the TAR period. For example, if the TAR runs from February 1, through August 1, carry-over days for the month of February reflecting unattended, approved days in January will not be reimbursed.

The following conditions apply for carry-over days:

- A day may only be carried over into the calendar month following the calendar month in which it was authorized.
  - Days may not be carried over from one authorized TAR period to the next authorized TAR period. Therefore, carry-over days may never be billed during the first month of an authorized TAR.
- Up to four days may be carried over. The CBAS center must specify the days being billed as carry-over days.
- Recipient health records must reflect services rendered on the carry-over days. CBAS center attendance logs must reflect the recipient's actual attendance on all carry-over days.
- A statement of medical necessity for each carry-over day must be submitted on or with the claim. A TAR is not required for carry-over days. If the recipient needs more than four carry-over days during any calendar month, or needs additional days on an ongoing basis, then a change TAR must be submitted (see "Request for Increase in Days of Service [Change TAR]" on a previous page).
- Carry-over days may only be billed on the final claim of the month in which the carry-over day(s) was used.

Claims for carry-over days that do not meet the requirements specified above will not be paid.

Medical Necessity for Carry-Over Days

A statement of medical necessity for carry-over days must be included on or with the carry-over day claims. This statement must be specific to the participant and provide sufficient detail to explain why the carry-over day(s) should be reimbursed. Additional information justifying the medical necessity for the carry-over day(s) must be maintained in the participant's health record and available for State review upon request.

The claims statement must demonstrate one of the following:

- The recipient is returning after an absence due to illness, injury or hospitalization and requires an additional day(s) of CBAS services in the current calendar month to meet goals as specified on the recipient's IPC.
- The recipient is returning after an absence in which the recipient's physical or mental condition declined, and requires an additional day(s) to meet IPC goals.
- The recipient is returning after an absence that resulted in missing a CBAS service necessary for the improvement and/or ongoing stabilization of the recipient's physical or mental condition, and in the absence of an extra day during the current calendar month, the CBAS service cannot be rescheduled in a timely manner to meet the recipient's needs.

DHCS may conduct random audits of CBAS claims. CBAS centers may be asked to provide additional documentation before the claim for a carry-over day is reimbursed.

Request for Additional Therapy Services

CBAS centers have the ability to obtain authorization for additional physical and occupational therapy services (speech therapy was eliminated as an optional Medi-Cal service in 2008) for a specific participant if the CBAS center has or will meet its required monthly therapy hours (CCR, Title 22, Sections 54423 and 78419). A separate TAR must be submitted by the CBAS center to the San Francisco Medi-Cal Field Office for authorization. Documentation that the CBAS center has or will meet its required therapy hours, and that the additional therapy hours being requested exceed the required monthly therapy hours and that the requested additional therapy hours are necessary to carry out the IPC for the specific participant, must be attached to the TAR.

Documentation of medical necessity for additional therapy must accompany the TAR that is submitted to the San Francisco Medi-Cal Field Office. The TAR must clearly state that services will be rendered at the CBAS center. If a participant is a Health Care Plan (HCP) enrollee, the center must contact the HCP for plan-specific information about authorization and billing for additional therapy services.

CBAS centers that provide additional physical and/or occupational therapy services and meet the criteria stated above should refer to the "Appendix" of this manual for physical and occupational therapy service policy and maximum reimbursable rates.

Transportation

Transportation between a participant's home and a CBAS center is included in the per diem reimbursement rate paid to a CBAS center and is not separately reimbursable. Non-emergency medical transportation providers enrolled in the Medi-Cal program may obtain TARs for non-emergency medical transportation from the CBAS center to medical appointments. These TARs must document medical necessity for the transportation and must state clearly that the service is being provided from a CBAS center.

Note: Medical appointments should not preclude the minimum of four hours per authorized day of participant attendance at the CBAS center. Such appointments should be scheduled to allow four hours of CBAS center attendance and participation in scheduled activities.

STATE USE ONLY

SERVICE CATEGORY

5

TYPEWRITER ALIGNMENT Elite Pica

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY 40 41 42 43

TYPEWRITER ALIGNMENT Elite Pica

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO.

2 TYPE OF SERVICE REQUESTED: DRUG [ ] OTHER [X]

REQUEST IS RETROACTIVE? YES [ ] NO [X]

IS PATIENT MEDI-CAL ELIGIBLE? YES [ ] NO [X]

PROVIDER PHONE NO. (916) 555-5555

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS
- CBAS CENTER
- 140 SECOND STREET
- ANYTOWN CA 958235555

3. PROVIDER NUMBER 0123456789

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.)

4 DOE, JANE

MEDI-CAL IDENTIFICATION NO. 5 90000000A95001 SUFFIX 6

SEX 7 F AGE 85 DATE OF BIRTH 8 010227

STREET ADDRESS 4589 CENTER STREET

CITY, STATE, ZIP CODE ANYTOWN CA 98523

PHONE NUMBER AREA (916) 555-5555

PATIENT STATUS: HOME [ ] BOARD & CARE [X] SNF / ICF [ ] ACUTE HOSPITAL [ ]

DIAGNOSIS DESCRIPTION: HYPERTENSION

ICD-9-CM DIAGNOSIS CODE 4019

MEDICAL JUSTIFICATION:

SEE ATTACHED INDIVIDUAL CARE PLAN. ADMIT ON 040912. 100 DAYS REQUESTED FOR 6-MONTH PERIOD. REQUESTING AVERAGE OF 4 DAYS/WEEK.

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:

1 APPROVED AS REQUESTED [ ] DENIED [ ] DEFERRED

2 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) [ ] JACKSON VS RANK PARAGRAPH CODE

BY

MEDI-CAL CONSULTANT I.D. # 34 DATE 35 REVIEW COMMENTS INDICATOR 44

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b) 36 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

LINE NO	AUTHORIZED Y/N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9	10	CBAS SERVICES 040912 THRU 043012		11 S5102	12 14	$
2	13	14	CBAS SERVICES 050112 THRU 053112		15 S5102	16 16	$
3	17	18	CBAS SERVICES 060112 THRU 063112		19 S5102	20 18	$
4	21	22	CBAS SERVICES 070112 THRU 073012		23 S5102	24 16	$
5	25	26	CBAS SERVICES 080112 THRU 083112		27 S5102	28 19	$
6	29	30	CBAS SERVICES 090112 THRU 093012		31 S5102	32 17	$

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

Mary Brown — SIGNATURE OF PHYSICIAN OR PROVIDER

Program Director — TITLE

040212 — DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM DATE 040912 38 TO DATE 093012

TAR CONTROL NUMBER

39 OFFICE SEQUENCE NUMBER 23456789 PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

PROVIDER COPY

50-1 03/07

Figure 1. CBAS TAR Example.

INDIVIDUAL PLAN OF CARE (IPC)

Completion and Form Example

The *Individual Plan of Care* (IPC) must be completed by the CBAS center and submitted with a TAR. This form is used to substantiate the medical need for CBAS services. The IPC should be developed based on the multidisciplinary team's assessment and signed by all appropriate team members. Refer to an example of a blank IPC form in the *Adult Day Health Care* provider manual on the Medi-Cal website and explanations of form items on the following pages of this section. A current copy of the IPC must always be maintained in the participant's health record.

IPC Queries

For questions about completing the TAR, IPC or adjudication of specific TARs, providers should call the Los Angeles Medi-Cal field office. For questions about the CBAS program requirements, providers should call CDA at (916) 419-7545.

Submitting With TAR

The IPC and signature page of the H&P form (when implemented) must be submitted with the initial TAR and sent to the Los Angeles Medi-Cal field office for review. If the IPC, TAR or signature page of the H&P form is incomplete and/or missing, or there is insufficient information to determine medical necessity for CBAS services as specified in the Darling et al. v. Douglas et al. Settlement Agreement and the *Community-Based Adult Services (CBAS)* section of this provider manual, the TAR will be deferred and an *Adjudication Response* notice will be sent to the CBAS center for resubmission of the TAR.

Explanation of Form Items The following box numbers and directions for completion correspond to fields on the IPC form.

Box Number	Instructions for Completion
Top of Page One	**a. PARTICIPANT NAME:** Enter the participant's name. **b. TAR CONTROL NUMBER (TCN):** Enter the eight-digit TAR Control Number from the attached TAR (paper TAR) or the 10-digit number from the (eTAR). **c. CENTER NAME:** Enter the CBAS center's name. **d. PROVIDER NUMBER (NPI):** Enter the CBAS center's Medi-Cal ID number or National Provider Identifier (NPI). **e. DATES OF SERVICE:** Enter the dates of service (DOS) requested on the TAR. The start date is the first requested date of service after the assessment days are completed and the Participant Agreement is signed. If there was an extended break in service (the previous TAR lapsed [expired]), the new start date is the first requested date of service after the participant's return to the center. Authorization of a TAR for CBAS services is limited to a period of not more than six months duration.

Box Number	Instructions for Completion
(1) Information Box	a. Check the appropriate box regarding TAR type. • **INITIAL TAR –** the TAR for the first admission to this CBAS center or return to this CBAS center after a break in service (previously lapsed [expired] TAR). • **REAUTHORIZATION TAR –** a TAR for continuing services at the CBAS center for which the immediately preceding TAR was authorized. • **CHANGE TAR –** the TAR for additional day(s) that is submitted within the current six-month TAR cycle. The IPC must be revised to support medical necessity for the increased number of days requested. b. Enter planned number of days of attendance per week. This number must support what is planned at the time of the multidisciplinary team assessment. c. Enter the tuberculosis (TB) clearance date. This date is the date the person's TB test was determined to be negative. This date must be within one year prior to the participant's admission to the CBAS center. d. For initial TARs check *Yes* or *No* to indicate whether the signature page of the H&P form is attached to this TAR and IPC. If not attached, the TAR will be deferred. **Note:** Until the H&P form is implemented, check *NA*.

Box Number	Completion Instructions
(2) Diagnoses and ICD-9-CM Codes	Enter the list of diagnoses and the corresponding ICD-CM codes applicable to the participant. The most current codes must always be used. Enter all diagnoses and codes that have been provided or confirmed by the participant's personal health care provider(s). These diagnoses codes must be the same diagnoses and ICD-9-CM codes as entered on the TAR and the *UB-04* claim form; they must be the same codes as provided or confirmed by the participant's personal health care provider(s).
(3) Medications (frequency and dosage not required)	List all active prescription medications and/or over-the-counter medications and supplements being taken by the participant. If the participant is not taking any medications or supplements, please check *No Medications or Supplements* box. An "active prescription" is described as a current and non-expired prescription. **Note:** Frequency and dosage are not required.
(4) Active Personal Medical/ Mental Health Provider(s) (if known)	List all active personal medical and mental health care providers for the participant, if known, including their names, addresses and phone numbers.
Criteria Verification Boxes: • All circles checked must be supported by appropriate documentation in the participant's health record. • All information presented must be based on multidisciplinary team assessments completed at the center. • All participants must meet the specified criteria of any one or more of the following categories (A through E; Boxes 5-9).	
(5) Category A	• If the participant does NOT fall within Category A, check the first circle. • If the participant falls within Category A, check circles to indicate whether the participant meets the specified criteria. **Note**: If the participant falls within Category A and does not meet the specified criteria, the TAR will be denied unless the participant also falls within another Category and meets the specified criteria for that Category.
(6) Category B	• If the participant does NOT fall within Category B, check the first circle. • If the participant falls within Category B, check circles to indicate whether the participant meets the specified criteria. **Note:** If the participant falls within Category B and does not meet the specified criteria, the TAR will be denied unless the participant also falls within another Category and meets the specified criteria for that Category.

Box Number	Completion Instructions
(7) Category C	• If the participant does NOT fall within Category C, check the first circle. • If the participant falls within Category C, check circles to indicate whether the participant meets the specified criteria. **Note**: If the participant falls within Category C and does not meet the specified criteria, the TAR will be denied unless the participant also falls within another Category and meets the specified criteria for that Category.
(8) Category D	• If the participant does NOT fall within Category D, check the first circle. • If the participant falls within Category D, check circles to indicate whether the participant meets the specified criteria. **Note**: If the participant falls within Category D and does not meet the specified criteria, the TAR will be denied unless the participant also falls within another Category and meets the specified criteria for that Category.
(9) Category E	• If the participant does NOT fall within Category E, check the first circle. • If the participant falls within Category E, check circles to indicate whether the participant meets the specified criteria. **Note**: If the participant falls within Category E and does not meet the specified criteria, the TAR will be denied unless the participant also falls within another Category and meets the specified criteria for that Category.
(10) Participants with Mental Illness	This box is specific to the participant with one or more mental illness diagnoses pursuant to CCR, Title 9, Section 1830.205 (the Diagnostic and Statistical Manual of Mental Disorders). The participant and/or family/caregiver must be informed of the availability of a referral to County Mental Health at the time of the initial TAR (unless another agency has made the referral) and at any time the participant is given a new mental illness diagnosis by an appropriately licensed professional. a. Check the appropriate circle(s) as they apply to the specific participant. b. If the participant does not have a mental illness diagnosis, check the *No Mental Illness Diagnosis* box. c. If *Referral Not Made* is checked, please state why referral was not made. **Note:** If this information is not completed, the TAR will be deferred.

Box Number	Completion Instructions
(10) (*continued*) Participants with Mental Illness	d. "Included" mental health diagnoses Participants with one or more of the following diagnoses must be informed of the availability of a referral to County Mental Health: • Pervasive developmental disorders • Disruptive behavior and attention deficit disorders • Feeding and eating disorders of infancy and early childhood • Elimination disorders • Other disorders of infancy, childhood or adolescence • Schizophrenia and other psychotic disorders • Mood disorders • Anxiety disorders • Somatoform disorders • Factitious disorders • Dissociative disorders • Paraphilias • Gender identity disorder • Eating disorders • Impulse control disorders not elsewhere classified • Adjustment disorders • Personality disorders • Medication-induced movement disorders e. "Excluded" mental health diagnoses Participants with diagnoses other than the diagnoses listed above in c, are not included in the mental health consolidation agreement and do not need to be referred to County Mental Health. These include: • Mental retardation • Learning disorder • Motor skills disorder • Communication disorders • Autistic disorder/other pervasive • Tic disorder • Delirium, dementia, amnesic and other cognitive disorders • Mental disorders due to a general medical condition • Substance-related disorders • Sexual dysfunction • Sleep disorders • Antisocial personality disorder • Other conditions that may be a focus of clinical attention, except medication-induced movement disorders

Box Number	Completion Instructions
(11) ADL/IADL Limitations	a. For each ADL and IADL listed, check the appropriate column, *Independent, Needs Supervision, Needs Assistance* or *Dependent*. Descriptions of these terms are printed under the word. There must be a check in each row, for each ADL and for each IADL. • The participant must have limitations as specified under the category in which the participant qualifies for CBAS, when applicable: – These limitations must be related to the participant's chronic or post acute medical, cognitive or mental health condition(s) that qualified the participant for CBAS services (Boxes 5-9). – These limitations must require that at least assistance or supervision is necessary when performing the relevant ADLs/IADLs. – The assistance or supervision required must be in addition to any non-CBAS support(s) currently being received in the participant's place of residence. **Note:** If the participant does not have limitations as specified under the category in which the participant qualifies for CBAS, the TAR will, at a minimum, be deferred. • Any limitation in ADLs and/or IADLs due solely to culture, language, or any condition other than the medical, cognitive, or mental health condition(s) will not be considered for eligibility/ medical necessity determination. b. If *Dependent* is checked for any ADL/IADL, the department encourages the center to describe the participant's status and any related services the CBAS center will provide or arrange to have provided in Box 23, *Additional Information*, if not explained elsewhere in this IPC. **Note:** Assistance with ADLs or IADLs (example, the In-Home Supportive Services (IHSS) worker does the housework for the participant) does not automatically indicate that the participant is "dependent." The CBAS center should explain the participant's status if "dependent" is checked for any ADL or IADL.

Box Number	Completion Instructions
(12) Current Assistive/Adaptive Devices	a. Check the appropriate circle(s) to indicate the assistive/adaptive devices currently being utilized by the participant. b. If no devices are currently being utilized, please check *None*. c. If *Other* is checked, please specify device(s).
(13) Continence Information	a. Check the appropriate circle(s) to indicate any continence conditions currently present. b. If no special continence conditions are present, please check *None*. c. If *Other* is checked, please specify.
(14) Feeding Information	a. Check the appropriate circles(s) to indicate any feeding conditions currently present. b. If no special feeding conditions are present, please check *None*. c. A therapeutic or special diet means a diet ordered by the personal health care provider and modified from a regular diet in a manner essential to the treatment or control of a particular condition, disease or illness, including texture-modified diets. d. If *Other* is checked, please specify. **Note:** If the participant is receiving tube feedings or intravenous feedings at home and will not be receiving food at the CBAS center, check *Other* and explain.

Box Number	Completion Instructions
(15) Non-CBAS Center Support(s)/ Services (if known)	a. If this information is unknown to the CBAS center, please check *Not Known* and explain. b. Check the appropriate circle(s) to indicate non-CBAS center support(s)/service(s) currently being utilized by the participant. c. If no support(s) is currently being utilized, please check *None*. d. Provide the information as requested under the *Describe* column, specific to how or why the support service is insufficient to maintain the individual in the community. • If *IHSS/PCSP Services* is checked, please specify the hours per week or month that are authorized for the participant. • If *Targeted Case Management* is checked, please specify frequency. • If *Other Paid Caregiver(s)* is checked, please specify frequency. • If *ICF/DD-H* is checked, please provide information as relevant to the participant. • If *Lives in Community Care Licensed Facility* is checked, please describe how or why the service(s) provided in the community care licensed facility is insufficient. • If *Participates in a HCBS waiver* is checked, please check the appropriate circle to indicate which waiver the participant is enrolled and describe how or why the service(s) provided in the waiver is insufficient. **Note:** Utilization of any of the above supports/services shall NOT automatically disqualify the participant for CBAS services. If, in addition to the above specified support(s)***/***service(s), the participant requires CBAS services to remain in the community, such CBAS services, in the quantity documented on the TAR and IPC to be medically necessary shall be authorized.

Box Number	Completion Instructions
(16) Non-CBAS Center Support(s)/ Services (if known)	Check the appropriate circle(s) next to any of the non-CBAS center support(s)/service(s) the participant received within the last six months. For *Home Health Agency Services* and *Hospice Services*, specify if these supports/services are currently being received. a. If this information is unknown to the CBAS center, please check *Not Known* and explain. b. If the participant has not received any non-CBAS center supports/services, please check *None*. c. If *Home Health Agency Services* is checked, please also specify whether or not the participant is currently receiving home health agency services. If so, please list the specific services and their frequencies (for example, three times per week) in the table provided. d. If *Hospice Care* is checked, please explain the nature of the services received and also specify whether or not the participant is currently receiving hospice services. If so, please list the specific services and their frequencies (for example, three times per week) in the table provided. e. If *Urgent Care* is checked, please explain the nature of the services received. f. If *Mental Health Services* is checked, please explain the nature of the services received. g. If *Emergency Department* is checked, please explain the nature of the services received. h. If the participant received other non-CBAS center supports/services, please check *Other* and specify the type and nature of the services received. **Note:** Current and continuing utilization of home health agency, urgent care, mental health or emergency department services shall NOT automatically disqualify the participant for CBAS services. If, in addition to these support(s)**/**service(s), the participant continues to require CBAS services to remain in the community, such CBAS services, in the quantity documented on the TAR and IPC to be medically necessary shall be authorized. While utilization of Hospice Care services shall <u>not</u> automatically disqualify the participant for CBAS services, any care for the Hospice-related condition(s) that a physician has certified as likely to result in a life expectancy of six months or less is the responsibility of the Hospice provider. Such services are not reimbursable to the CBAS center provider and the need for these services cannot be considered when determining eligibility/medical necessity for CBAS services.

Box Number	Completion Instructions
(17) Risk Factors	a. Check the appropriate circle(s) that applies to this participant at the time of IPC completion. b. If *Other* is checked, please specify the risk factor(s).
(18) At Risk for Admission to Acute or Institutional Care (if known)	a. Check the appropriate circle(s) next to the level of institutional care to which the participant has been admitted within the last six months. • If this information is unknown to the CBAS center, please check *Not Known* and explain. • If the participant has not been admitted to any institutional care, please check *None*. • If *Acute Care Hospital* is checked, please explain the nature of the admission. • If *Nursing Facility* is checked, please explain the nature of the admission. • If *ICF/DD or ICF/DD-N* is checked, please explain the nature of the admission. • If the participant has been admitted to another level of institutional care, please check *Other* and specify the institutional care and explain the nature of the admission. b. State the last known discharge date from acute or institutional care.

Box Number	Completion Instructions
(19) Required (Daily Core) Services: Professional Nursing Services	a. Check *Yes* or *No* to indicate whether the participant will be receiving professional nursing services as specified, in this TAR period. **Note:** If the participant will not be receiving professional nursing services, the TAR will be denied. b. The "N1" through "N5" designations found in this box are intended to enable coding of the (CBAS) center health record for documentation of core services.
(19) (continued) Required (Daily Core) Services: Personal Care Services/Social Services	a. Check *Yes* or *No* to indicate whether the participant will be receiving personal care services/social services as specified, in this TAR period. **Note:** If the participant will not be receiving personal care and/or social services, the TAR will be denied. b. The "P1," "P1a," "P1b," "P2," "P2a," "P2b" and "P2c" designations found in this box are intended to enable coding of the CBAS center health record for documentation of core services.
(19) (continued) Required (Daily Core) Services: Therapeutic Activities	a. Check *Yes* or *No* whether or not the participant will be receiving therapeutic activities as specified, in this TAR period. **Note:** If the participant will not be receiving therapeutic activities, the TAR will be denied. b. The "A1" and "A2" designations found in this box are intended to enable coding of the CBAS center health record for documentation of core services.

Box Number	Completion Instructions
(19) (continued) Required (Daily Core) Services: Meal Service	a. Check *Yes* or *No* to indicate whether or not the participant will be receiving meal services as specified, in this TAR period. b. The "M" designation found in this box is intended to enable coding of the CBAS center health record for documentation of core services. **Note:** If the participant is receiving tube feeding or intravenous feedings at home and is not able to eat food, this criterion is considered met. Please explain in Box 14.
(20) TAR for Reauthorization of ADHC Services	Check *Yes, No* or *NA* to indicate whether this is a reauthorization TAR AND the participant's condition would likely deteriorate if the CBAS services were denied, as specified. • *"Yes"* means the TAR is a reauthorization TAR AND the participant meets the condition specified. • *"No"* means the TAR is a reauthorization TAR AND the participant does NOT meet the condition specified. • *"NA"* means the TAR is NOT a reauthorization TAR. **Note:** If the participant does not meet this criterion on a reauthorization TAR, the TAR will be denied.

Box Number	Completion Instructions
(21) Participant's Individual Plan of Care (Core Services) (must be consistent with information provided in this IPC)	Pursuant to W&I Code, Section 14550.5, each participant must receive each of the core services on each day of attendance at the CBAS center. Indicate that these core services will be provided by completing each column for each of the core services. a. Description of terms (left-hand column, CBAS Core Services): • Professional Nursing Services – those services specified in W&I Code, Section 14550.5(a). • Personal Care Services – those services specified in W&I Code, Section 14550.5(b)(1). • Social Services – those services specified in W&I Code, Section 14550.5(b)(2). • Therapeutic Activities – those services specified in W&I Code, Section 14550.5(c). • Physical Therapy Maintenance Program – procedures and exercises that are provided to a participant, pursuant to Section 1580 of the *Health and Safety Code*, in order to generally maintain existing function. These procedures and exercises are planned by a licensed or certified therapist and are provided by a person who has been trained by a licensed or certified therapist and who is directly supervised by a nurse or by a licensed or certified therapist (pursuant to Section 1570.7(h) of the *Health and Safety Code*). **Note:** Physical therapy maintenance is considered a therapeutic activity. • Occupational Therapy Maintenance Program – procedures and exercises that are provided to a participant, pursuant to Section 1580 of the *Health and Safety Code*, in order to generally maintain existing function. These procedures and exercises are planned by a licensed or certified therapist and are provided by a person who has been trained by a licensed or certified therapist and who is directly supervised by a nurse or by a licensed or certified therapist (pursuant to Section 1570.7(h) of the *Health and Safety Code*). **Note:** Occupational therapy maintenance is considered a therapeutic activity.

Box Number	Completion Instructions
(21) (*continued*) Participant Individual Plan of Care (Core Services)	• Meal Services – those services specified in W&I Code, Section 14550.5(d). Please specify whether the participant will be receiving a regular or special diet; if a special diet, please be specific as to the type of special diet (such as low salt, diabetic, etc.). **Note:** If the participant is receiving tube feeding or intravenous feedings at home and is not able to eat food, this criterion is considered met. Please explain in Box 14. Services provided directly to the participant by the Registered Dietitian should be placed on the IPC under *Registered Dietitian Services* (see Box 22, Participant Plan of Care *Additional Services*). b. Description of terms (across the top, header row): • Participant Problem – the symptom or demonstrated behavior (not diagnosis) that is identified or validated by the assessment done by both the participant's personal health care provider (or the CBAS staff physician) and the CBAS center's multidisciplinary team. The problem must: – Be related to the diagnosis or condition, – Be amenable to interventions available in the CBAS center, – Be specific to the individual participant, and – Provide a measurable starting point such as a beginning grade or strength, a percentage, degree, level or range. Enter those participant problems for which the CBAS center staff will provide treatments or interventions during this TAR period. **Note:** "At risk for" when used to describe a participant problem requires more detailed specification of the risk and what the CBAS center will be doing to prevent the actual risk event.

Box Number	Completion Instructions
(21) (*continued*) Participant Individual Plan of Care (Core Services)	• Treatments/Interventions – the prescribed, proposed and/or recommended means of resolving or mitigating the participant problem that must: – Reflect both the assessment done by the participant's personal health care provider (or the CBAS staff physician) and the assessment done by the CBAS center's multidisciplinary team, – Be related to the problem, – Be practical for implementation in the CBAS center setting, and – Be specific to the individual participant. Please include whether the treatment/intervention is individual or group and any out-of-center activities. • Frequency of Treatment/Intervention – how often the treatment/intervention is provided; for example, two times per week. • Discipline Specific Objective/Goal of Treatment/Intervention expected outcome recommended by the specific discipline that will be providing the treatment/intervention that must: – Reflect both the assessment done by the participant's personal health care provider (or the CBAS staff physician) and the assessment done by the CBAS center's multidisciplinary team. – Be related to the intervention, – Be attainable by the individual participant, – Be measurable, and – Include timelines for achievement if the time frame is other than six months (or length of TAR period). **Note:** The participant's plan of care, as summarized in Boxes 21 and 22, must support the number of days being requested on the TAR. The medical necessity for and the frequency and duration of CBAS services are used to determine the number of days authorized and therefore MUST be clearly and succinctly described in each column of the plan of care. Boxes 21 and 22 will be used by the field offices as the primary information to determine the appropriate number of days to authorize for each participant.

Box Number	Completion Instructions
(22) Participant's Individual Plan of Care (Additional Services) (must be consistent with information provided in this IPC)	Complete each column for each row. For those services that the participant will not be receiving this TAR period, please write *NA* across the row to indicate that the specified service will not be provided. a. Description of terms (left-hand column, CBAS Additional Services) (for purposes of the bundled CBAS per diem rate of reimbursement): • Physical Therapy – services provided by a California licensed physical therapist within his/her scope of practice. Pursuant to Section 1570.7(i) of the *Health and Safety Code*, physical therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function, when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team." • Occupational Therapy – services provided by a California licensed occupational therapist within his/her scope of practice. Pursuant to Section 1570.7(i) of the *Health and Safety Code*, occupational therapy "may also be proved by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function, when there is an expectation that condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team." • Speech and Language Pathology Services – services provided by a California licensed speech and language pathologist within his/her scope of practice. • Registered Dietitian Services – services such as nutrition assessment, counseling or education provided directly to the participant and/or family/caregivers by a California registered dietitian within his/her scope of practice.

Box Number	Completion Instructions
(22) (*continued*) Participant Individual Plan of Care (Additional Services)	• Mental Health Services – services provided by a mental health professional, pursuant to CCR, Title 22, Sections 54325 and 78337 as listed: licensed psychiatrist, licensed psychologist, licensed clinical social worker, or an advanced practice mental health registered nurse within his/her scope of practice; or services provided by one of the following when in consultation with one of the above specified mental health professionals as listed: recognized psychiatric/psychological assistant; licensed marriage, family and child counselor; licensed marriage and family therapist; certified rehabilitation counselor; or recognized associate clinical social worker within his/her scope of practice. **Note:** "In consultation with" is not meant to infer a supervisory relationship. All staff must remain within his/her scope of practice. • Other – any service not specified above that the participant will receive during this TAR period (other Medi-Cal services must be billed separately by the rendering provider). Indicate the specific service. These services continue to be governed by Title 22, Section 54311. b. Description of terms (across the top, header row): See above, Box 21. Under *Treatments/Interventions*, include the planned amount of the treatment/intervention (for example, 15 minutes) and the duration of the treatment/intervention (for example, for two weeks). **Note:** The participant's plan of care, as summarized in Boxes 21 and 22, must support the number of days being requested on the TAR. The medical necessity for and the frequency and duration of CBAS services are used to determine the number of days authorized and therefore must be clearly and succinctly described in each column of the plan of care. Boxes 21 and 22will be used by the field offices as the primary information to determine the appropriate number of days to authorize for each participant.

Box Number	Completion Instructions
(23) Text Box for Additional Information	This is an optional, open text box for communication of any additional information that may assist in justifying eligibility/medical necessity for the requested CBAS services. Do not repeat information previously explained. Indicate the box number of the IPC that is being discussed.
(24) Signatures of Multidisciplinary Team and Program Director	a. The registered nurse, social worker, physical therapist and occupational therapist must sign and date all initial IPCs. The registered nurse and social worker must sign and date all reauthorization IPCs. The remainder of the multidisciplinary team must sign and date the IPC if their particular service will be rendered to the participant during this TAR period. **Note:** The CBAS center must maintain all assessments completed by the individual disciplines of the multidisciplinary team in the participant's health record, including the date the assessment was done and the signature of the person who did the assessment. b. The participant's personal health care provider or CBAS center physician must sign and date all IPCs. c. The program director must sign and date all IPCs. The TAR will be authorized only back to the date when the program director certifies that assessments were completed and that the participant meets the eligibility/medical necessity criteria for CBAS services. This date is known as the "effective date." • All assessments must be completed prior to the first day of authorized CBAS service (CCR, Title 22, Section 54309). • The program director's signature shall serve as verification that all assessments have been completed. a. If the "effective date" as noted by the program director is the third assessment day, the CBAS center may bill the day as a regular CBAS day or as a bill-direct assessment day, but not both. e. If, at the time the TAR and IPC are submitted to the field office, one or more of the required multidisciplinary team signatures (excluding the personal health care provider or the CBAS center physician, and program director) are missing, please explain why and when these signatures will be obtained in Box 23, *Additional Information*. • The field office may ask for the signature page of the IPC at a later date to confirm all signatures. • An IPC received without the participant's personal health care provider, CBAS center physician or program director's (or his/her designee) signature will be deferred.